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What does performance theory have to teach us about the treatment of severe and persistent mental illness (SPMI) in prison?

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Abstract

Deinstitutionalization of psychiatric hospitals, which occurred in the 1970's, led to an overwhelming number of mentally ill individuals within jails and prisons. In fact, correctional facilities have become the mainline providers of mentally ill inmates; however, these facilities' primary form of intervention is psychotropic medication. Although beneficial in some instances, when viewed through the lens of Goffman's theories of performance and stigma, simply providing medication promotes the role of *mental patient*. Arguably, within correctional facilities, medication management assists in maintaining security in the institution (i.e., external change); however, this prohibits the inmate from internal change, which might otherwise be facilitated via a secure therapeutic relationship. Given the stripping of one's former identity upon entrance to correctional facilities, performing the role of mental patient may be an enticing way to serve a sentence. In other words, it is a stigmatized identity; thus, less demanding. This paper will explore changing society's view of what is normal in hopes of de-stigmatizing the role of mental patient. This would include accurately identifying those with organic mental illness and those who are behaviorally motivated, with an emphasis on providing a therapeutic environment centered upon secure attachments between patient and provider. Keywords: Goffman; severe and persistent mental illness; performance theory; stigma; and prison.

By the late 1800's, Dorothea Dix had successfully enacted a movement that facilitated the transition of psychiatrically ill individuals out of prisons and into psychiatric hospitals. Her efforts highlighted the belief that these individuals deserved to be treated as patients and not managed as criminals. With the advancement of new medications aimed at reducing psychiatric symptoms, as well as efforts to cut costs, deinstitutionalization in the 1970's closed hospital doors. Although well-intentioned, this movement resulted in what Dorothea Dix had fought hard against: an overwhelming number of mentally ill individuals who found themselves housed within jails and prisons (Human Rights Watch, 2003; Treatment Advocacy Center, 2010). The following essay will explore the treatment of individuals diagnosed with severe and persistent mental illness (SPMI), particularly within correctional settings. Using Erving Goffman's theories on performance and stigma within "total institutions," such as correctional facilities, I will formulate an innovative way of conceptualizing the treatment of the severely mentally ill within correctional environments. As such, I will propose and defend alternative treatment options, namely the need to create an environment that centers upon a sound and secure therapeutic relationship between provider and patient.

Correctional facilities have become a mainline provider of mental health services (Fellner, 2006; Human Rights Watch, 2003; Treatment Advocacy Center, 2010). When compared to state psychiatric hospitals, there are more than three times the number of mentally ill individuals within jails and prisons (Fellner, 2006; Treatment Advocacy Center, 2010). Additionally, the Bureau of Justice Statistics (2006, p. 1) reported at midyear 2005, more than half of all prison and jail inmates had a mental health problem. Fellner (2006) further noted the rate of mental illness in prisons is "two to four" times higher than in the general public

population (p. 392). Overall, severe and persistent mental illness within correctional institutions is being reported in high numbers.

The Treatment Advocacy Center (2010) reported at least 16% of inmates in jails and prisons, compared to a study in 1983 that suggested 6.4%, have a serious mental illness. Moreover, the National Commission on Correctional Health Care (2002) (as cited in Human Rights Watch, 2003, p. 17) reported the following statistics:

On any given day, between 2.3 and 3.9 percent of inmates in State prisons are estimated to have schizophrenia or other psychotic disorder, between 13.1 and 18.6 percent major depression, and between 2.1 and 4.3 percent bipolar disorder (manic episode).

Furthermore, the Bureau of Justice Statistics (2006) reported among jail inmates, 54% met criteria for mania, 30% met criteria for major depression, and 24% met criteria for a psychotic disorder. These and the above statistics suggest there is a serious need to address the treatment of SPMI within correctional environments, as despite Dortehea Dix's efforts, jails and prisons have become a fundamental location for the treatment of the mentally ill.

Inmates diagnosed with mental illness are entitled to receive mental health treatment (Bureau of Justice Statistics, 2006; Human Rights Watch, 2003; Kenney, 2013). Generally speaking, the Eighth Amendment of the U.S. Constitution states individuals have a right to remain free from cruel and unusual punishment. Moreover, *Estelle v. Gamble* (1976) held that a violation of the Eighth Amendment included correctional staff's "deliberate indifference" to an inmate's need for medical treatment (Human Rights Watch, 2003; Kenney, 2013). This was expanded upon in the case of *Inmates of Allegheny County Jail v. Pierce* (1979), as "deliberate indifference" was applied to mental health needs (Kenney, 2013).

Internationally, there are also a number of protections for mentally ill inmates. The International Covenant on Civil and Political Rights (ICCPR), the Covenant on Economic, Social and Cultural Rights, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), the United Nations Standard Minimum Rules for the Treatment of Prisoners (Standard Minimum Rules), the Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment, and the Basic Principles for the Treatment of Prisoners all provide guidelines to ensure specialized care for those diagnosed with mental illness (Human Rights Watch, 2003, pp. 204-206). The legal obligation to provide mental health treatment, coupled with the high quantity of mentally ill inmates, highlights the importance of providing competent psychological treatment within correctional facilities.

The administration of psychotropic medication has become a prominent form of mental health treatment within correctional facilities. According to the Bureau of Justice Statistics (2001) one in ten state inmates are taking psychotropic medications. Due to inadequate funding, which limits the number of qualified staff to adequately treat (i.e., assess, develop treatment plans, initiate treatment, and monitor), inmates' treatment often primarily consists of psychotropic medication (Fellner, 2006; Treatment and Advocacy Center, 2010).

The importance of maintaining the safety of the community and other inmates is emphasized within correctional settings. In fact, balancing mental health needs and security needs within institutions is a constant battle, with security concerns primarily taking precedence (Fellner, 2006; Human Rights Watch, 2003). Goffman (1961) also references the "conflict" between maintaining "humane standards" and "institutional efficiency" (p. 78). He notes staff's daily activities primarily revolve around the contradiction of actual duties performed and

performing the duties that the total institution's officials say must be done (i.e. working toward rehabilitation yet only having the resources to meet with each client every other week). Goffman further states, "This *people-work* is not quite like personnel work or the work of those involved in service relationships; the staff, after all, have objects and products to work upon, not services, but these objects and products are people" (p. 74). A result of believing one is working with a product, not a person, fuels inaccurate beliefs about how the "product" will act. Goffman provides the example that staff may believe a hospital patient will act out "for no reason" or that a sick inmate will attempt to purposely spread their disease to staff. Thus, Goffman notes staff members are required to control inmates in the name of the institutional aims, namely the safety of the institution and surrounding community. He also highlights the notion that inmates' statuses dictate how they will be treated and what can be expected from them. These factors exacerbate and justify the social and emotional distance required of interactions with those identified as *inmates*.

A primary challenge associated with the belief that social and physical distance from an inmate is required, in order to maintain safety within the facility, is it creates a conundrum for "helping staff," such as nurses, psychiatrists, psychologists, and social workers. More specifically, this belief creates an environment where helping staff often feel as if they are not able to provide the service and care that such a profession would, for example, be able to provide to an individual in the community. For example, psychologists in the community often refer to their patients by their first names; however, psychologists within a prison are often required to refer to the individual by their last name. Goffman (1961) describes the helping professionals as "captives," as their presence establishes the inmates are being treated humanely, despite the institution's frequent disinterest in providing these services (p. 92).

When I am working with individuals diagnosed with SPMI within a correctional setting, I spend a considerable amount of time developing and nourishing the therapeutic relationship. However, given the nuances of correctional environments, this approach is often conducted “under the radar.” This “black market” approach to treatment is often considered taboo, as you would never want to be observed treating an inmate as if they were *actually* a human. Although digressing slightly to my personal approach to therapy, I believe it is imperative to consider the importance of secure attachments when working with this population. Within a prison setting, a secure attachment, as described by Ainsworth, Blehar, Waters, & Wall (1978), is often viewed as inappropriate and unnecessary. However, within the larger context of psychotherapy, creating a patient/therapist relationship focused on connection, consistency, and security; in my opinion, is the foundation that facilitates lasting change. Within total institutions, such as prisons, sustaining an avoidant attachment, albeit in the name of security, is problematic. Goffman’s assertions about the conflict between “humane standards” and “institutional efficiency,” emphasize the social and emotional distance between inmate and staff. Thus, the socio-cultural context within prison environments prevents secure therapeutic attachments, which might otherwise assist the inmate with a greater ability to emotionally self-regulate; therefore, possibly decreasing acting out behavior.

Given helping staff’s difficulty in providing ideal care to an individual within total institutions, the belief inmates are subhuman, and the ongoing conflict between security precautions and treatment aims, it appears the reliance on psychotropic medication is a middle ground between these factors. More specifically, according to the Bureau of Justice Statistics (1999; 2006) inmates with mental illness accounted for more rule violations and assaults compared to inmates without a mental health problem. Additionally, the Bureau of Justice

Statistics (1999; 2006) reported that taking a prescribed medication for a mental health problem was the primary form of treatment intervention offered within jails and prisons compared to counseling or admission to an inpatient care facility. More specifically, “About 27% of State prisoners, 19% of Federal prisoners, and 15% of jail inmates who had a mental problem had used prescribed medication for a mental problem since admission” (Bureau of Justice Statistics, 2006, p. 9). Moreover, across state prison and jail inmates, “professional therapy” was also a form of treatment; however, it consistently fell second to the use of psychotropic medication (Bureau of Justice Statistics, 2006, p. 9). Given the high usage of psychotropic medication, it is no wonder the use of such medication, from the time of an inmate’s admission, rose from 12% in 1997 to 15% in 2004. What is also striking is the percentage of state inmates, who received mental health therapy, since their admission, remained relatively stable across this time period. These statistics suggest that prescribing medication is used as a management tool within correctional facilities, as it is a way to enhance safety; however, the high usage of this treatment intervention is likely also being used as an avenue to support the façade that institutions are also providing humane treatment.

Controlling inmates with psychotropic medications does not take into account the whole individual, including the individual’s surrounding environment (Human Rights Watch, 2003). Although temporarily effective in diminishing symptoms and pacifying violent behavior, prescribing a “cocktail” of antipsychotics should not be *the* answer. Although medications are meant to improve an individual’s functioning, which one would assume would also mean a release to a less restrictive environment, these individuals continue to reside in prison. They are not being released to the community; consequently, medications promote the identity of mental patient and risk major side effects without some of their primary benefits. To combat this

temporary solution, many correctional facilities have implemented therapeutic programming to address the multifaceted treatment of SPMI; however, medication management continues to be a prominent solution (Human Rights Watch, 2003). Psychotropic medication being the frontline of mental health treatment in correctional facilities is problematic. Of course there are many circumstances in which psychotropic medication is the best choice; a good test might be whether the same person with the same symptoms would be treated chemically if he were not in a prison. However, according to *Ruiz v. Estelle* (1980) (as cited in Human Rights Watch, 2003) simply providing medication does not meet the correctional institution's obligation to provide mental health treatment. Similarly, as previously discussed, maintaining security within total institutions requires sustaining avoidant attachments between staff and inmate. Continuous interactions that perpetuate this type of attachment increase the likelihood of acting out behavior; thus, psychotropic medications are used to control this "bad" behavior. As such, medication management assists in maintaining security in the institution (i.e., external change); however, this prohibits the inmate from internal change, which might otherwise be facilitated via a secure therapeutic relationship.

Given my experience within state and federal correctional institutions, I understand there are a multitude of facilities pursuing and implementing innovative treatment programs for their mentally ill inmates; however, statistics continue to report medication management is a primary form of mental health treatment. I am not arguing for the cessation of psychotropic medication; however, I am curious about how providing medication perpetuates the identity of *mental patient*. More specifically, how does the frequent prescribing of psychotropic medication emphasize and perpetuate this identity? Do the high rates of medication administration contribute to a culture within jails and prisons that encourage inmates to be mentally ill? The role of

subdued mental patient will not be effective in the community after release. Simply providing psychotropic medication to an inmate twice a day does not teach an inmate how to perform other roles (i.e. friend, employee, neighbor, etc), which will be essential to their success upon release. Said another way, living for years or even decades within an environment that reinforces particular ways of interacting with others (i.e., insecure/avoidant attachment) and ways of coping with distress (i.e., psychotropic medication), individuals affected by SPMI perform in accordance with these detrimental ways of approaching the world. Correctional environments facilitate performances that, in the general psychological world, are antithetical to positive change. As previously referenced, my experiences within correctional settings de-emphasize, and often times disapprove of, relational components of treatment to those affected by SPMI. As such, the importance of the relationship between patient and provider is overshadowed by sexier and more alluring therapeutic interventions, such as cognitive behavioral therapy (CBT). That is not to say CBT interventions do not have a place within the treatment of SPMI populations because I believe they do; however, to the detriment of our patients, creating a relationship based upon safety, connectedness, and consistency is almost always forgotten. Therefore, my goal for this essay is to provide a new lens to the treatment of SPMI within correctional institutions. Based on the above statistics, it is clear the current system is ineffective. Mental health treatment in jails and prisons has turned largely into a dispensary, relief from boredom, and escape from scary pods to less frightening mental health units. Something must change.

Erving Goffman's *The Presentation of Self in Everyday Life* (1959) explores social interactions via a "dramaturgical approach" (p. 240). Goffman posits that individuals offer a "performance" in the presence of others. He defines performance as the following:

All the activity of an individual which occurs during a period marked by his continuous presence before a particular set of observers and which has some influence on the observers.” (p. 22)

Consequently, an individual’s actions in the presence of others, or his performance, are important for impression management. It is in the performer’s best interests to control the impression he provides to his audience because this influences how they will respond. As a result, the performer, via his performance, can influence the definition of a situation. As Goffman (1959) further notes, an individual will perform in a way to provide an impression to others that is in his (i.e. the actor’s) best interest. Said another way, individuals will present themselves in a way that is beneficial for them. Barnhart (1994) provides an important point in regard to performers’ tendency to present in a way that is favorable to themselves. He stated, “The performance exists regardless of the mental state of the individual, as persona is often imputed to the individual in spite of his or her lack of faith in-- or even ignorance of--the performance” (para. 2). As a result, regardless of an individual’s capacity to understand that they are offering a performance, for example, individuals with formal thought disorders, all individuals offer a performance in the presence of others.

An important feature of a performance is the “front.” Goffman (1959) notes the “front” is the part of the performance that is typically fixed and assists in defining the situation for the observers (p. 22). In other words, the “front” includes the individual characteristics or parts of self that are projected during the performance to transmit a particular impression of the social role that the performer wishes to provide. As Goffman further suggests, when an individual decides to “take on” a specific role, a particular front has already been established for that role (p. 27). Additionally, a performance is considered “effective” if the observers’ act in a way that

signals to the performer that he has communicated the impression he (i.e. the actor) sought to convey (Goffman, p. 6). For example, if an individual decides he wants to effectively perform the role of “good student,” he will complete assignments, attend class, build relationships with professors, and will be viewed by others as an intelligent and hardworking student. In other words, the actor knows what actions will define the performance of “good student” and performs effectively when others agree he is a good student. Goffman states individuals know what front to present because society has previously agreed upon particular actions that are associated with a role, and society gives corrective feedback to actors. He terms this consensus “collective representation” (p. 27). It is also important to note a performance will include and highlight values of society. This contributes to the performer’s ability to present the most “idealized” version of the role (p. 35). Consequently, fronts and roles will vary given the setting and audience. In this way, an individual can be said to have a “multiplicity of selves” (Goffman, 1963, p. 63).

In addition to performing a particular front, the individual will also likely impart “dramatic realization[s]” into their performance (Goffman, 1959, p. 30). These activities “dramatically highlight and portray confirmatory facts that might otherwise remain unapparent or obscure” (p. 30). The purpose of these emphasized actions is to highlight and enforce the role he is attempting to portray. In the example of a “good student,” not only must the performer complete required assignments and obtain acceptance of being a good student from others, he must highlight his performance of “good student.” This may include commenting upon the long hours he spent researching and writing the assignment.

As previously established, the performer acts in a particular fashion (i.e. portrays a specific front) as a means to convey a specific impression to observers, and these actions serve to

highlight the social role the performer has intended to play. Additionally, the definition of this role has been previously decided upon by society, and is considered a success when the audience believes and accepts the role of the performer. Actually, of course, society does not decide on roles; instead, roles that work in given situations are reinforced by the smooth operation of the situation and role-definitions that do not work are corrected.

In his book *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, Goffman (1961) explores the concept of “total institutions,” as well as individuals’ entrance into these types of facilities. He reports that every institution has particular “tendencies,” and that the tendencies of “total institutions” are “symbolized by the barrier to social intercourse with the outside and to departure that is often built right into the physical plant, such as locked doors, high walls, barbed wire, cliffs, water, forests, and moors” (Goffman, p. 4). In other words, total institutions are characterized by a separation, physically and socially, from the outside community. As such, correctional facilities are considered a type of total institution.

Goffman (1961) outlines specific characteristics of jails and prisons that allow them to qualify as a total institution. These factors include no separation of “spheres of life” (i.e. individuals sleep, work, and socialize with peers all in the same place); all parts of daily life are conducted in front of a large group of others, who are all treated the same and possess the same schedule of activities; all activities are decided upon and scheduled by others and occur at a set time; and lastly, the activities within the institution are carried out to fulfill the goals of the larger institution (p. 6), which include containment and safety.

As previously noted, individuals perform roles to convey impressions to others. An individual who possesses a law degree, attends court proceedings, and defends clients who pay him to act in their best interests, is performing the role of “lawyer.” However, when an

individual enters a total institution, he is “stripped” of the social role that he maintained in the larger community (Goffman, 1961, p. 14). Individuals then begin a “series of debasements, degradations, humiliations, and profanations of self” which are initiated upon entrance to the total institution (Goffman, p. 14). Goffman asserts the individual’s separation from the larger community, for an extended period of time, cuts his ties with roles and identities previously held, and he is no longer allowed to sustain the identity he once possessed, as “role dispossession” occurs (p. 14). As such, an individual who acted as a lawyer in the community cannot perform this social role, as defined by society’s standards, while incarcerated. The same is true for the roles of father, husband, restaurant patron, and sports fan.

As Goffman (1961) asserts, intake interviews, photographs, fingerprinting, storage of personal possessions, being issued institutional clothing and minimal self-care supplies, obtaining an identification number, as well as being assigned a cell are all ways in which an individual is essentially trained to fit the role of *inmate*. Additionally, actions and personal histories that are often kept “backstage” are made public (Goffman, p. 24). For example, inmates lack a sense of privacy, as they are required to receive medical care in the presence of numerous staff, incoming and outgoing mail is censored, and they must often use the toilet in front of others. These factors put the individual into the role of *inmate*, as his prior social roles are no longer available. This is due to no longer possessing the “equipment” necessary to perform that previous role, given the enforcements within the total institution (Goffman, p. 21). The “disfigurement[s] and defilement[s]” (i.e. the stripping of prior social roles in their entirety) are problematic, as they are not aligned with the individual’s prior beliefs about the self (Goffman, p. 35).

In addition to the de-identification that occurs upon entering total institutions, Goffman (1961) reports that inmates are also subject to “echelon authority,” as “*any* member of the staff class has certain rights to discipline *any* member of the inmate class” (p. 42). Again, this is drastically different from any social role the individual possessed while not incarcerated. For example, Goffman notes that, typically, an individual is subject to reprimanding from his employer while at work, but not in his home, but they can be disciplined by anyone, even other inmates, while incarcerated. Consequently, inmates often live in constant fear of breaking the rules, and that remaining incident free requires “persistent conscious effort” (Goffman, p. 43). Given the loss of sense of self, the constant fear of being punished, and consistent efforts to conform to the new society they live in, individual distress is understandable.

Given the loss of self that occurs upon admission to a total institution, “secondary adjustments” are often utilized to create an impression of sustained control over the environment (Goffman, 1961 p. 55). Secondary adjustments provide “evidence” that the inmate is still an individual with control over his surroundings. Other ways to cope with their loss of identity include forming a collective sense of inequality and injustice among their fellow inmates, forming cliques, or even sexual partners. As such, the social systems that develop between inmates may be a way to reject and rebel against others, rather than having to reject oneself (p. 58). Consequently, it is clear that being stripped of one’s social identity, and being confronted with the requirement to accept another (i.e. *inmate*), is a psychologically stressful process. Goffman comments on the distressing nature of this process. He notes, “Relief from economic and social responsibilities--much touted as part of the therapy of mental hospitals--is one, although in many cases it seems that the disorganizing effect of this moratorium is more significant than its organizing effect” (Goffman, p. 56). Therefore, the institution provides

inmate numbers, specific clothing, and other rules often for security and logistical reasons; however, this is extremely disorganizing for those going through the process.

In order to adapt to the disappearance of one's sense of self, the individual will need a novel social role. Goffman (1961) describes five roles that the inmate can adopt in order to acclimate and thrive in their new setting. First, inmates can exhibit "situational withdrawal." Goffman describes this adaptive role as the following: "The inmate withdraws apparent attention from everything except events immediately around his body and sees these in a perspective not employed by others present" (p. 61). Other terms to describe this adaptation are "regression" or "prison psychosis" and are often thought of as an "effectively irreversible" role (pp. 61- 62).

Second, Goffman (1961) notes inmates can take an "intransigent line," in which the individual deliberately challenges the rules of the institution, including refusing to cooperate with staff. This role, although defiant, creates a deep involvement with the institution, as the individual will likely have frequent confrontations with staff, who in turn devote a significant amount of time to this individual. An inmate housed in a segregation unit has usually adopted this role, as initial defiance ultimately leads the inmate to have more interactions with the institution than if he had not been unruly. This role is often temporary, as the inmate will shift to a more passive form of adaptation, such as situational withdrawal (p. 62).

The third method of adaptation is "colonization" (Goffman, 1961, p. 62). In short, colonization is described as using the inmate's experience of the outside world as a way to illustrate the desirability of being incarcerated. Goffman notes these individuals will likely be described as "finding a home" within the institution, and will frequently employ self-sabotaging techniques, such as receiving sanctions near their release, in order to remain within the

institution. However, these individuals, in order to maintain the front of *inmate* will deny their satisfaction with their incarceration, especially in front of their peers.

“Conversion” is another adaptive strategy (Goffman, 1961, p. 63). This role includes a performance of the “perfect inmate,” as these individuals will attempt to “take over the official or staff view of himself” (Goffman, p. 63). For example, within psychiatric institutions, Goffman notes that conversion can take two forms: the individual can adopt the psychiatric view of himself or can mimic the actions of staff (i.e. similar dress, helping with duties, etc) (p. 64).

Goffman (1961) describes the fifth role as “playing it cool” (p. 64). This includes utilizing secondary adjustments, conversion, colonization, and loyalty to the other inmates. Goffman further asserts this particular role provides the “maximum chance” of leaving the institution “physically and psychologically undamaged” (pp. 64-65). As such, inmates who “play it cool” are able to effectively adapt to the role necessary to function with other inmates, with staff, and living within the institution. It seems that performing this role indicates the individual’s ability to accurately perform a variety of roles; consequently, the role of mental patient is less alluring and is recognized as a role that does not have long-term benefits. Despite the various roles available, it is important to understand that each adaptation technique is a way to manage the discrepancies between their social identities outside and inside prison walls.

Faced with the necessity of adopting a new social role, individuals within a total institution are also in constant reminder that they have failed at life on the outside. This failure is illustrated during the admission process, and is continually reiterated via interactions with staff and other inmates (Goffman, 1961). Goffman further notes, “As a result, the inmate tends to feel that for the duration of his required stay--his sentence--he has been totally exiled from living” (p. 68). This “social disconnection” needs to be examined, as institutions, historically, have failed to

provide inmates with “gains,” such as training or money, which can be transferred outside prison walls (Goffman, p. 68). As a result, individuals begin to engage in “removal activities,” (i.e. playing cards, engaging in staff sponsored activities, gambling, or sexual relationships) which essentially act as distractions to remove the inmate, temporarily, from his current situation (Goffman, p. 69). Goffman further notes:

Every total institution can be seen as a kind of dead sea in which little islands of vivid, encapturing activity appear. Such activity can help the individual withstand the psychological stress usually engendered by assaults upon the self. (pp. 69-70)

Therefore, if time within the total institution is internalized as “life wasted” it seems logical the individual would begin to identify with a role that was beneficial for him, but not necessarily in his best interests. Such a role may include that of the mental patient, as this role would provide an escape from the pressures of the total institution, but is not an effective long-term solution.

Society has created and defined groupings of individuals that are present within particular social settings. Specific attributes or characteristics of these groupings, which are considered to be “ordinary and natural” are also established (Goffman, 1963, p. 2). As Goffman further notes, there are anticipated characteristics of each social group, and others expect these constructed attributes to be present when an individual who belongs to that particular group is encountered. Consequently, society attributes expected characteristics of a group into a collective “social identity,” which allow others to identify the individual’s particular social group membership (Goffman, p. 2). Therefore, upon entering a building that has been identified as the “mental health building,” an individual whose hair is unruly, whose clothes appear wrinkled, and who may be muttering to themselves, is expected to possess the social identity of “mentally ill” and not to possess the social identity of “psychologist.” These characteristics are expected from

someone who suffers from mental illness, and not from a psychologist. As such, based on the setting, individuals are assigned “virtual social identities,” (i.e. an identity based on “assumptions as to what the individual before us ought to be”) (Goffman, p. 2). Consequently, notions about what is normative are dependent on the setting. Based on the “virtual social identities,” which will be termed from this time forward simply as, “social identity,” the concept of stigma develops. In regard to stigmatizing an individual, Goffman notes:

He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive; sometimes it is also called a failing, a shortcoming, a handicap. (p. 3)

Therefore, a stigmatized individual is someone who does not possess or live up to the attributes that society anticipates and has assigned to him. Goffman (1963) further states, “Note, too, that not all undesirable attributes are at issue, but only those which are incongruous with our stereotype of what a given type of individual should be” (p. 3). Consequently, when examining the social setting of correctional institutions, being an inmate discredits the performance of any other role. In other words, an inmate cannot speak to correctional staff on an equal footing, because inmate status discredits the role of conversational partner or friendly acquaintance. More specifically, they are viewed as a collection of individuals who were unable to conform to the social standards of others, and are viewed by the larger society as expendable and inferior. In fact, Goffman posits that inmates are perceived as “failing to use available opportunity for advancement in the various approved runways of society” (p. 144). Consequently, the term “stigma” will be utilized to refer to “discrediting” attributes that are not aligned with the expected or normative attributes of a given social setting (p. 3).

The difficulty in being stigmatized is that “normals” view the stigmatized individual as less than, inferior, and thus treat them that way (Goffman, 1963, p. 5). Consequently, this behavior leads to disrespectful relationships that are justified and excused by the stigma. For example, within a correctional institution, a correctional officer who mimics an inmate housed on the mental health unit is “justified” in her actions because the inmate is mentally ill and cannot understand he is being laughed at. However, these kinds of relationships between “normals” and the stigmatized can have long-term effects. For example, the stigmatized individual believes he should be treated just like any other person, but likely knows what others think about him. Knowing that others view him as expendable and laughable is internalized so that the individual comes to believe that he is in fact, less than others (Goffman, p. 7). As such, it can be an extremely shaming and belittling experience when individuals believe they cannot live up to the attributes of “normals.” Additionally, as within a correctional institution, Goffman discusses the tension that develops between staff and inmates based on anticipated attributes:

Each grouping tends to conceive of the other in terms of narrow hostile stereotypes, staff often seeing inmates as bitter, secretive, and untrustworthy, while inmates often see staff as condescending, high handed, and mean. Staff tends to feel superior and righteous; inmates tend, in some ways at least, to feel inferior, weak, blameworthy, and guilty.” (p. 7)

Within a correctional facility, being housed on a mental health unit leads to “automatic identification” of *mental patient*; therefore, others expect this inmate to perform the role associated with being mentally ill (Goffman, p. 84). As such, the individual “forgoes” being viewed as possessing other, likely more acceptable social identities, and accepts treatment as a stigmatized individual (Goffman, 1959, p. 13). Goffman further notes:

In consequence, when an individual projects a definition of the situation and thereby makes an implicit or explicit claim to be a person of a particular kind, he automatically exerts a moral demand upon the others, obliging them to value and treat him in the manner that persons of his kind have a right to expect. (p. 13).

Therefore, one facet of the role of mental patient is to appear mentally ill, regardless of other personal identities that the individual possesses, as this is what is expected of a mental patient.

Given the shame involved in being a member of a stigmatized group, the concept “secondary gains” seems like a logical escape (Goffman, 1963, p. 10). An example of this concept is when an individual with a harelip uses this stigmatizing attribute as a “protection from social responsibility” (p. 10). When viewing this concept in relation to severe and persistent mental illness in prison, being associated with the social identity of *mental patient* would essentially provide the individual with protection from the “normal” expectations of prison life. More specifically, the individual could withdraw from interactions with others, and pressure to conform to the daily life of prison, and accept his new identity of inmate, could be avoided. Goffman (1963) further discusses the concept of “minstrelization,” “whereby the stigmatized person ingratiatingly acts out before normals the full dance of bad qualities imputed to his kind, thereby consolidating a life situation into a clownish role” (p. 110). Consequently, when examining the social identity of *mental patient* within the context of a correctional institution, there appears to be some benefit to being stigmatized as mentally ill as a relinquishment of the demands of the inmate role.

The nature of society means that individuals with a stigmatized identity and *normals* have frequent contact with each other. Goffman (1963) defines these interactions as “mixed contacts” (p. 12), as when an individual identified as a mental patient is in the presence of, or speaking

with, their treatment team. These situations present difficulties for the stigmatized individual, namely fears about how he will be received and the fear that he will be defined by his stigma.

Goffman provides an example of these fears:

And I always feel this with [law-abiding] people--that whenever they're being nice to me, pleasant to me, all the time really, underneath they're only assessing me as a criminal and nothing else. It's too late for me to be any different now to what I am, but I still feel this keenly, that that's their only approach, and they're quite incapable of accepting me as anything else. (p. 14)

In other words, individuals are defined by their stigmatized identity. When given the identity of *mental patient*, what would be viewed as commonplace interactions, such as becoming frustrated, are viewed as demonstrations of the mental illness (Goffman, 1963). Goffman (1961) notes, "Normality is never recognized by the attendant in a milieu where abnormality is the normal expectancy" (p. 85).

Goffman (1963) posits an individual is likely to become aware of his stigma upon his entrance into a total institution via his interactions with others. Goffman notes:

When the individual first learns who it is that he must now accept as his own, he is likely, at the very least, to feel some ambivalence; for these others will not only be patently stigmatized, and thus not like the normal person he knows himself to be, but may also have other attributes with which he finds it difficult to associate with." (p. 37)

In other words, it appears upon entrance into a total institution the individual is faced with the reality he is now stigmatized. He is no longer the self that he believed himself to be, and is forced into an identity by his mere presence within the institution. In the case of a jail or prison,

the individual is faced with the stigma of *inmate*, (except among other inmates) and via his interactions with others, including mixed interactions, he finds what roles are available to him while carrying his stigmatized identity. Not only is the social identity of *inmate* identified as a stigmatized group, but within this category, there are also social identities that are further stigmatizing. In other words, within society as a whole, the identity of inmate is a stigmatized identity. However, within a correctional institution, the identity of inmate is normative because one would expect to find inmates within a prison. However, being identified as mentally ill within a prison setting would be a stigmatized social identity because, although an available social role of an inmate, it deviates from what is expected of an inmate. As such, the mere presence of an individual housed within a mental health unit sends the message to those around him that he is a mental patient, and thus should perform behaviors associated with this role. As such, inmates who also possess the status of *mental patient* can withdraw from the pressures of the total institution because the role of a *mentally ill inmate* is less demanding than the role of simply *inmate*. Consequently, there appears to be some benefit to performing the role of mental patient.

To cope with a stigmatized identity, individuals attempt to manage the extent to which this identity becomes known, and by controlling the amount of information that is known about this identity. Therefore, individuals attempt to hide their stigma by concealing “stigma signs”; by choosing when to reveal their stigmatized identity, in whole or in part, to others; or by avoiding situations that are stigmatizing.

Despite these options, stigmatized individuals begin to accept their stigmatized identity (Goffman, 1963, p. 101). Goffman states, “He is advised to reciprocate naturally with an acceptance of himself and us, an acceptance of him that we have not quite extended him in the

first place” (p. 122). Therefore, “phantom acceptance” emerges, as the stigmatized individual’s acceptance into “normal” culture is conditional, and in reality, non-existent (Goffman, p. 122).

Goffman further illustrates this point:

Thus, even while the stigmatized individual is told that he is a human being like everyone else, he is being told that it would be unwise to pass or to let down ‘his’ group. In brief, he is told he is like anyone else and that he isn’t... This contradiction and joke is his fate and his destiny. (p. 124)

Consequently, there appears to be only one real solution to the problem of stigma: change society’s view of what is “normal.” Goffman (1963) states, “Society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories. Social settings establish the categories of persons likely to be encountered there” (p. 2). As such, expanding society’s beliefs about what attributes are included in an individual’s “social identity” is a necessary component to eliminating stigma. Individuals find they are stigmatized when some aspect of their identity prohibits them from performing other roles. For example, a person who is housed in a correctional facility is deemed an inmate, and this identity element forbids them from performing the role of accomplished businessman, best friend, or simply, human being. Consequently, although a certain identity element is not inherently stigmatized, when an individual engages in efforts to manage a particular identity element, it confirms the defective nature of that aspect of identity; thus, creating stigma. As such, the solution to stigma is to change the way others react to stigmatized identity elements. There would be no need to “pass” or to engage in efforts to manage the stigmatized identity element because others would be more willing to accept a wide range of attributes believed to be normal. These points are pertinent to the exploration of the treatment of

severe and persistent mental illness within correctional institutions. More specifically, being able to explore ways to make the role of mental patient less stigmatizing (i.e., changing the way others view mental illness), and less desirable, may enhance the possibilities for more effective treatment of severe and persistent mental illness.

It is apparent from the above descriptions that staff and inmates have particular roles they must fulfill. Staff need to maintain the control of inmates, which includes identifying them as solely inmates, while other staff must maintain this control while engaging in actions that give off the impression that they are being treated humanely (i.e. being provided treatment, etc.). Additionally, staff members are expected to maintain social and emotional distance from inmates. Conversely, inmates are required to perform specified roles, often roles they are unfamiliar in performing. They are stripped of their former roles and identities, and instructed to play the role of inmate. Goffman (1963) notes that the pressure to conform to strict roles within the total institution is problematic because the roles are performed by individuals who are “deeply trained in other roles and other possibilities of relationship” (p. 111). He further asserts:

The more the institution encourages the assumption that staff and inmate are of profoundly different human types (as, for example, by rules prohibiting informal social intercourse across the staff-inmate line) and the more profound the drama of difference between staff and inmate, the more incompatible the show becomes with the civilian repertoire of the players, and the more vulnerable to it.” (p. 111)

In other words, this role differentiation does not work. It is unsustainable. I question why a performance, which is unsustainable, is being used within a total institution that houses individuals who will be back in the community. Goffman (1961) states numerous, if not most, social interactions and policies reiterate the difference between staff and inmate. This difference

becomes interpreted as human and non-human and is perpetuated in most all daily interactions. However, as Goffman emphasizes, and my experience of hearing stories about “staff being compromised” highlights, the line between staff and inmate is thin. Goffman reports, “I assume these identity concerns point to the difficulty of sustaining a drama of difference between persons who could in many cases reverse roles and play on the other side” (p. 112).

Goffman (1961) reports it is often discovered that the “craziness” of the mental patient is in fact due to being a product of the situation rather than of the mental illness (p. 130). He also notes psychiatric symptoms can be a temporary response to the stressful process of admission to a total institution. This lends credit to the idea of a performance, as regardless of the mental illness, the performance of *mental patient* is a product of the institution itself. Goffman notes a component of the “prepatient phase” (i.e. prior to being identified as mental patient), the individual experiences a loss of self. They begin to be troubled by the knowledge that they are losing control, and this is threatening. As cited in Goffman (1963) an individual begins to process “a failure at being human--a failure at being anything that one could respect as worth being” (p. 131). Although he was speaking about a mental institution, the same can be said for an individual entering prison. Goffman (1961) asserts that the loss of self that is experienced upon entering a total institution, even if mental illness is not a factor in the admission to the total institution, the loss of control and feelings of failure, may lead the individual to perform the role of mental patient.

It has been established that upon entering a total institution, such as a prison, the individual automatically becomes an *inmate*. This role is pre-formed because there are a limited amount of available roles on the inside. However, one available role to the inmate is that of the *mental patient*, which as previously stated, is available via situational withdrawal. Consequently,

an inmate has the option to perform the role of mental patient, which has its own consequences, negative and positive. Goffman (1961) notes that despite differences in mental illness, the degree to which they are mentally ill, or how other people would describe them, individuals who are labeled *mental patient* share a “common fate” and a “common character” (p. 129). In other words, despite the presence of “real” mental illness or not, individuals who perform the role of mental patient will be treated as such. In correctional institutions, it seems the treatment for “real” or preformed mental illness is psychotropic medication. Consequently, for the purposes of this paper, the role of mental patient will be explored in hopes of providing more of an understanding of this role, and how de-stigmatizing this role, as well as making this role less desirable, can assist in more effective treatment interventions for individuals diagnosed with severe and persistent mental illness.

One may ask why any of this matters. Colloquially, when speaking to family, friends, and other colleagues, I am often asked, “Why would you want to work in a prison?” or something to the effect of, “I think they should just lock them up and throw away the key.” The sentiment is one that is found within our nation’s history: the notion these individuals should be punished, not rehabilitated. In fact, Dorothea Dix challenged this belief when she asserted these individuals should reside in the community. Resorting to medication management as the primary intervention, in my opinion, is aligned with this notion, as it is a way to “treat” without investing time and energy into treatment aimed at long-term rehabilitation. Medication helps people adjust to prison life, but it does not help them change their way of reacting to situations.

I am committed to the rehabilitation of mentally ill inmates. Although frequently preached within correctional institutions, I believe the practice of this philosophy is sporadic. In addition to this void, there are additional reasons why housing mentally ill individuals within

correctional settings is problematic. Correctional systems spend less money on mental health care, which perpetuates the “revolving door” effect, as inmates are not receiving adequate treatment or aftercare services; high numbers of mentally ill inmates requires higher staffing needs, which financially, is often difficult; mentally ill inmates pose a greater management risk; and lastly, correctional officers are hired to maintain the safety and security of the correctional facility, not to deal with mentally ill individuals (Treatment Advocacy Center, 2010). These factors provide more evidence to suggest the need to carefully examine and scrutinize the treatment of SMPI within correctional institutions.

Mental illness in its organic form exists in nature. Advances in technology and research support this notion. Therefore, this paper is not meant to insinuate that all mental illness is a performance of symptoms given an individual’s environment (although even the diabetic performs diabetes according to the situation he is in). The above striking statistics, my own experience working within jails and prisons, and the hundreds of mental health professionals working within correctional facilities are a testament to the reality that mental illness within correctional institutions exists. However, as Goffman posits, individuals choose and perform a role when they enter a total institution. Whether this role is behaviorally motivated or influenced by the “perfect storm” of biological and environmental factors, roles are assumed. As previously opined, individuals enter a total institution and are completely stripped of their former identity. They are forced to abandon all familiar roles they once performed, and are pushed to inhabit a new identity: inmate. As Fellner (2006) posits, “Prison conditions are hard on mental health in general...The impact of these problems is worse for prisoners whose thinking and emotional responses are impaired by schizophrenia, bipolar disease, major depression, and other serious mental illnesses” (p. 391). The bare walls, cold floors, skinny mattresses, loud noises, isolation

from loved ones, and pressure to follow written and unwritten codes is enough to make me want to “check out” from reality. Therefore, given these stressful conditions, it makes sense that performing the role of mental patient may provide, if nothing else, temporary relief from the barren and unwelcoming environment of prison.

People are stigmatized when they do not conform to the set upon performance (i.e., when they do not play their role appropriately). Given the five available roles in prison, people play roles they believe they can pull off because, to avoid stigmatization, one must play a role that can be performed adequately. In other words, given the lack of pro-social roles available in a prison environment, the stigma associated with nonconformity, the forced abandonment of one’s previous identity, as well as the painful environmental conditions one is forced to survive within, there are benefits to playing the role of mental patient. Specifically, an individual can “check out.” There is then a “legitimate” reason to disengage from others, which is reinforced by being given psychotropic medications. There is no incentive to engage in behaviors and perform roles that are pro-social and would benefit the individual long term because this would mean coming face-to-face with a desolate and unwelcoming environment.

Given the incentives to present as mentally ill in prison, yet the reality of biological mental illness, it is imperative to differentiate the performance of the mentally ill patient between those who possess organic mental illness and those that may experience “prison psychosis.” The former will include individuals who suffer from a mental disease, and like people with schizophrenia in the community, their way of managing the disease should still be addressed. Their particular biological makeup, combined with current stressors (including the entrance to the total institution) creates the perfect stage for mental illness to emerge and persist beyond the prison walls. The latter will be individuals whose “mental illness” is considered a behavioral

function, a paucity of performable roles, solely in response to the entrance into a total institution, and whose illness will remit upon adjustment and/or release.

Before I explore treatment options for the biologically and behaviorally mentally ill, I believe it is important to note what must occur first. In order for individuals to perform the role of mental patient in more pro-social ways, whether biologically or behaviorally motivated, there appears to be no other solution than to start over. The entire system needs to be restructured and rebuilt to incorporate the notion that roles are being performed and more importantly, restructure the system in a way that de-stigmatizes the roles of mental patient and prisoner.

I realize a complete re-construction of the correctional systems in our nation is highly unlikely, given the politics and finances that would be involved in this sort of reconstruction. Although this is likely a reality, it is my hope that proposing an innovative way of viewing mental illness within corrections may ignite a movement within institutions to move toward this reconstruction. If anything, this paper will provide a new lens to view the mentally ill, and offer examples of positive change that may be able to occur, in some settings, given the current system. A major change would have to begin outside of prisons, one example of which would be to remind students that the Founding Fathers were all criminals (which is why we have an Eighth Amendment).

The primary premise of the reconstruction would be to increase the available roles within prison. In other words, it would be pertinent to provide more outlets for the individual to perform the role of a more pro-social mental patient; this might help de-stigmatize this role if normal can see the inmate or the mental patient looking more human. This means parting with the idea that prison is "life wasted." Despite the presence of biological or behavioral mental illness, individuals need to be able to incorporate aspects of their prior identity, and aspects of identities

that they can carry with them once their sentence is complete. Enhancing the clinician's and correctional staff's understanding of the inmate as a role performer will be crucial. This includes understanding aspects of the total institution and the limited possibilities that individuals are faced with upon entrance to these settings. Approaching inmates with the understanding that they are unable to perform the role they used to play, and subsequently, that anyone placed in a similar situation would act similarly, in my opinion, will decrease stigmatization and assist in creating more pro-social and lasting changes.

In order to obtain this new structure, total institutions need to become less total. Three important factors will assist in this process: improving environmental factors, hiring staff who have a genuine interest in improving the lives of those with SPMI, and a dedication to the development of skills and aspects of performance that transfer to the outside world.

Enhancing environmental factors would allow individuals to feel less like an animal in a cage and may allow them to function in a way that is less demoralizing and more humanizing. Providing mattresses that are thicker than a pad of paper, allowing the individuals to wear their own clothing, providing a variety of separated living areas, allowing for more personal touches to be placed within living quarters (i.e., pictures, curtains, flowers, etc.) would all be ways in which altering environmental factors would make entering such an institution less of a dehumanizing experience. Additionally, referring to the inmates as "patients" and speaking to them as Mr. and Ms. or by their first name, instead of inmate or prisoner, would assist the individual in feeling more human, and may create an environment among staff where the individual is seen and heard beyond the label of their diagnosis. These seemingly small changes may provide a way for the individual to maintain aspects of other identities; thus, de-stigmatizing their identity of mental patient and encouraging more pro-social performances of this role.

Regarding concerns this will make prisons too appealing and non-punitive, the actual punishments could be foregrounded including, especially, loss of liberties. For example, the individuals who lack the empathy needed to pro-socially function in the community, such as those deemed to be psychopaths would be housed in a separate facility that ensures they will be unable to harm or take advantage of others. Essentially a prison within the prison would be reserved for those who are unable to integrate into a less structured setting.

Employing staff that indisputably desire to work with individuals diagnosed with mental illness is essential. When interacting with individuals suffering from mental illness, “we have a human being for whom the bottom has completely fallen out, who struggles to maintain the most basic sense of integrity, perhaps even of existence itself. Then that individual becomes subject to an unrelenting experience of being personally discredited and pathologized” (Atwood, 2012, p. 63). Stigmatizing and pathologizing is inherent within total institutions; therefore, employing individuals who are educated on issues pertinent to the treatment of severe and persistent illness, including a compassionate and patient nature, is imperative.

Creating an environment that encourages meaningful relationships with these individuals will also be important. Therapeutic containment facilitates the exploration and acceptance of all identity elements, and is fostered by the therapeutic relationship. Conversely, correctional containment encourages a separation of identity elements, and is typically done under the guise of maintaining security. My personal beliefs about psychological health inform me that a healthy person is characterized by an integration of aspects of the self. The same could be said about a healthy system, such as correctional facilities (i.e., each part is working together with other parts within and outside the system). Given the separation of identity elements that is prominent within prisons, I would argue prisons are unhealthy to the psychological well being of its

inhabitants. Similarly, although this paper is about the performance of the role of prisoner, the performance of the role of psychologist is hampered within correctional institutions. Placing the safety of the facility above other institutional goals stigmatizes psychology staff who do not uphold the typical definition of what it means to be a staff member (i.e., upholding a stigmatized view of *inmate*). However, that could be the topic of an entirely different paper.

As Atwood (2012) posits, there will be a “shift away from the ideas of illness and disorder and toward the specific human experiences that are involved” (pg. 22). He further notes that the “medical model” perpetuates stigma and “reconfirm[s] the correctness of the diagnosis” (p. 46). As previously noted, this model assumes abnormality where abnormality is expected. Atwood further postulates that part of psychosis is a challenge to an individual’s sense of “I am”; therefore, creating genuine therapeutic relationships can be healing and empowering (pg. 55). As such, employing individuals who are ignorant to issues that affect individuals with SPMI and who seek employment in such a setting to satisfy a need to feel powerful and in control, would not occur. Instead, individuals found within these settings would possess a genuine desire to create meaningful relationships that will facilitate more pro-social ways of performing the role of mental patient in hopes of perpetuating lasting change.

There would also be an ample amount of staff employed at these facilities. Interdisciplinary teams, comprised of social workers, psychologists, psychiatrists, would all work together to provide treatment and effective release planning. Staff would not be overwhelmed with insurmountable caseloads, and would be able to devote the necessary time to each patient. Employees would no longer be held captive to the strict rules within total institutions and would be able to care for their patients with the empathy and concern that fueled their desire to enter the field in the first place. Additionally, inmate companions would be employed to assist staff in a

variety of tasks. They would complete 24-hour suicide watch, janitorial duties, electrical and plumbing issues, and would even facilitate leisure activities among the inmates, such as art projects, exercise groups, and movies. These companions would need to apply and be cleared by staff. They would also attend specialized training that would focus on interacting with mentally ill inmates. Employing inmate companions would lower the facility's overhead cost, but it would also provide these individuals a sense of purpose and a feeling of connectedness; characteristics that will be essential when attempting to foster pro-social behavior in the community.

Finally, there will be an emphasis on acquiring skills that make performing the role of mental patient less desirable and less stigmatizing. For example, providing in depth social skills training that uses innovative practices, such as role-plays and in vivo experiences; utilizing evidenced based practices, such as cognitive behavioral therapy and illness management and recovery, will be a mandatory priority on the units; incorporating family and other support systems into release planning will occur; and positive support and encouragement would be plentiful. The days of intermittent groups, facilitated by burnt out clinicians, will be a thing of the past. Emphasis will be placed on returning to the community and instilling skills that will transfer to the outside world, thus decreasing the benefits of performing the role of mentally ill. Consequently, although the changes I will propose may not be feasible within the current institutional set-up, professionals working within correctional institutions can begin to approach their patients with an understanding of what they are faced with. As such, incorporating some of these factors, when possible, will be a good start.

Now that general characteristics of the reconstruction of the system have been discussed, differences in the treatment of the biological and behavioral mentally ill can be mentioned. Given that a clinician within a correctional setting will encounter both of these performers, both

need to be considered. First, an accurate distinction between the two groups needs to be made prior to their entrance into a total institution. Specifically, an in-depth assessment of individuals will be pertinent. This includes careful and competent assessment and diagnosis of inmates in order to determine the presence of biological illness and situational illness. In a perfect world, inmates may be housed in a temporary facility in which the sole purpose is to study and evaluate them. There would be no time limit on this evaluative period, as emphasis would be placed on accurate diagnosis. This process would include licensed and competent professionals reviewing the individual's history (i.e., contact collaterals, review documents, etc.), a close analysis of their current functioning (i.e., inmate's self-report of symptoms, correctional and clinical staff's observations, comprehensive psychological testing), and given the advances in technology, brain scans to assess for brain abnormalities, would be completed. In sum, a complete and thorough evaluation of these individuals will need to be made, and the results of this evaluation will determine the permanent placement of this individual to serve their sentence. In sum, I envision a process that is able to accurately classify individuals into those who are experiencing situational psychosis and those who are biologically mentally ill. One goal of the present paper is to enhance accuracy by highlighting performance problems and situational demands.

It is essential to separate these two groups of mental patients because treatment interventions (aimed at decreasing the benefits of performing the role of mental patient) will differ. The role of mental patient within a prison, whether biologically or behaviorally based, is not a good rehearsal for the roles played upon release; therefore, it would be beneficial to explore ways to change the expectations of what is normal within a correctional institution. In other words, there would be no desire or incentive to play the role of mental patient because the factors

that would drive someone to perform this role (i.e., the desolate environment, stripping of one's identity, etc) would not exist.

Encouraging and reinforcing appropriate social interactions and social nuances, for example, would assist in making the role of mental patient less stigmatizing and would transfer positively to the outside community. As such, an important question with these individuals would be, "How can we shift treatment interventions to make being mentally ill less enticing." Playing the role of *mental patient* is less stigmatizing in correctional facilities because it is an acceptable role within that institution. However, when we are looking at individuals who will re-enter society at some point, we want to shift the focus to treatment that will allow them to adapt to play other roles, as the role of mental patient is stigmatizing and less acceptable within the larger community (i.e. one cannot walk the streets talking to their hallucinations, which is acceptable in a mental ward). In other words, they can pull off the role of mental patient well, but often this role is not good for them in the long term. Changing the environment and culture to make it less desirable to be mentally ill and more desirable to present as higher functioning is essential. In other words, providing treatment that emphasizes how to make the role of mental patient less discrediting should be the goal of these institutions. Importantly, this could include psychotropic medication; however, it would not be sole source of intervention.

Combating externalized stigma (i.e., stigma received from the external world, such as prison staff and environmental factors) is only one component to de-stigmatizing of the role of mental patient. I do not need countless years of clinical experience to state, when working with SPMI populations, internal stigma runs rampant. I am frequently faced with statements focused on the judgment and stigma these patients place on themselves. Sadly, this internal stigma often negates any "skills" based interventions. I believe placing a focus on the therapeutic relationship,

which would entail creating a secure attachment between clinician and patient, will also decrease the pull to present as mentally ill. Creating a therapeutic alliance that will allow the individual to be seen, independent of their diagnosis; heard; and ultimately understood, will create new ways of organizing their world, which will emphasize acceptance and connectedness. This is not an inherently novel way of approaching psychotherapeutic interactions, as this is often the basis of competent and effective psychotherapy in the larger community. However, in prison, this is drastically different from the avoidant relationships that are emphasized and maintained. No longer will a patient's identity revolve around being diagnosed SPMI, but the patient will hopefully experience a way of living that incorporates connectedness to other individuals and the larger society. The sort of connectedness that, as humans, we all crave.

Assuming individuals can be accurately classified, individuals who possess a biological component to their mental illness would be transferred to what might resemble a mental hospital versus a prison. I imagine this facility to be aesthetically pleasing and near a small community. This facility is concerned with providing mental health treatment in a way that encourages a severance of the reliance on the role of mental patient. Treatment will allow the individual to engage in more pro-social ways of functioning. Ways that will make the role of mental patient less stigmatizing in the real world; hence, discouraging the reliance on the pieces of that role that "work" within correctional institutions. Importantly, staff working with these individuals would recognize how mental illness contributed to their crime, and how treating the mental illness will decrease the probability of engaging in future criminal activity.

I imagine this institution to be separated based on levels of functioning and treatment adherence. These various levels would have different privileges, but would ultimately revolve around the advancement toward more independent living. More specifically, maybe the

“highest” level of treatment includes living in dormitory style housing. This would allow the individual to practice social skills, effective ways of dealing with conflict and stress, managing their medications, and engaging in real world activities, such as making meals and taking care of living spaces. Additionally, being involved in community activities, such as fundraising or church activities, will increase human connectedness and feelings of purpose. This will also assist in de-stigmatizing the role of mental patient while encouraging the role of “functioning citizen.”

Additionally, the need to balance correctional security and mental health treatment would be limited, as these facilities primary goal would be treatment oriented. SPMI affects an individual’s ability to perform certain functions of other roles (i.e. empathy, social skills, trust, etc.). By the mere presence of their mental illness, they are unable to effectively function within a total institution, as these institutions are not designed to meet their needs. For example, housing a mentally ill individual in segregation for extended periods of time, as a means of discipline, is contraindicated. Another example is hygiene. An individual whose entire shirt is soiled in old food, and who is found shuffling around the unit with unkempt hair and noticeable body odor, is not considered out of the ordinary, given they live on a mental health unit. However, this behavior would be stigmatizing in the real world, and there is no incentive, while in his current housing, to present as well groomed. Therefore, being in an environment such as a separate facility that is only home to those with a biological mental illness will allow for stigmatizing aspects of the mentally illness (i.e. deficits in social skills, empathy, hygiene, and judgment) to be addressed in a way that decreases stigma and emphasizes more pro-social ways of performing the role of mental patient.

Obtaining a separate facility for the biologically mentally ill would also decrease stigma because there would not be “normal” inmates who target such individuals for their own benefit. Specifically, outside of not knowing how to accurately perform another role, one reason that an individual with biological mental illness may prefer to present as mentally ill is because it is safer. Specifically, they will be treated as incapable and hopefully separated from those that may take advantage of them, such as antisocial individuals. Ultimately, the separation of those with biological mental illness, versus behavioral, is imperative. Individuals with biological mental illness, for a variety of reasons, do not know how to play other roles, and when forced into a total institution, they are forced into the role they know: mental patient. Consequently, teaching other roles and more importantly, how to effectively perform other roles, would be the main focus of these institutions and will be most effective without the judgmental eyes of those without mental illness. Ultimately, learning how to live with mental illness (i.e., learning how to perform more pro-social roles) and creating a secure bond with the clinician, which will transfer to subsequent relationships in the community, would be the ultimate goals of these facilities. Said another way, these facilities would aim to decrease external and internal stigma associated with severe and persistent mental illness.

Individuals who have been deemed, via the aforementioned in depth assessment, to express mental illness as a behavioral component to their entrance to the total institution will be treated differently. First and foremost, the primary form of intervention for these individuals would not be psychotropic medication. I imagine talk therapy, aimed at addressing and exploring the difficulties in adjusting to the total institution, to be a mandatory component of one's entrance into a correctional facility. Addressing the aspects that make mentally ill enticing, such as being given medication to make the time pass quicker and easier, being immune in a lot of

ways from the expectations of other inmates to engage with staff and other inmates, and as an escape from themselves, will be addressed in therapy. Acknowledging that the role of mental patient is likely a “comfortable” performance, yet exploring the pros and cons of this performance for long term functioning, will be crucial. Staff will approach these individuals with the understanding that this is a normal reaction to the entrance to such an institution and it is difficult; consequently, the stigma around being mentally ill will be reduced and individuals will desire to function in other ways because there would be no need to “dissociate” into “prison psychosis.” Providing humanizing interactions with the behaviorally ill will assist in decreasing the number of individuals who experience situational psychosis because there would be no need to perform such a role. Consequently, allowing them a space to adequately adjust to their environment could potentially decrease the amount of psychiatry and psychology services that are needed on individuals who would, otherwise be functioning relatively well. The concept of teaching or training inmates to adjust and cope with the situational stressor (i.e., entrance to the total institution) will be imperative. This could include a separate adjustment facility where every inmate is housed for an extended period of time, to adjust to the entrance to the total institution. Additionally, dialectical behavioral therapy (DBT), cognitive behavioral therapy (CBT), and interpersonal treatment interventions would likely be beneficial in teaching these individuals to manage and cope in more pro-social ways, similar to what they would need to do to adapt to change in the community.

In conclusion, I have proposed an alternative lens to the ways in which mental illness is understood within correctional institutions. Using Goffman’s theories of performance and stigma, exploring the treatment of mental illness within jails and prisons illustrates the flaws that are present within the current structure of corrections. Although the current structure of

corrections is not fully set up to accommodate the alternative views I have proposed, my hope for this paper is to encourage other correctional clinicians to challenge the way they view and treat their patients. I believe there are more effective solutions to the high number of mentally ill individuals within correctional facilities, and my hope is the field will begin to seriously contemplate these alternatives.

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